To:	Texas Department of Human Services Date: P. O. Box 149030 Mail Code: 952-X, Data Integrity Section Austin, Texas 78714-9030		
	Austin, Texas 70714-9030		
1.	Type of Request: (Circle A or B) A. Initial Manual B. Change from Prior Manual Certification Certification (Only complete Items 3, 4, 19 & 20)		
2.	Type of Recipient: (Circle One) Aged Blind Disabled (Circle One) Individual; Member of Couple; Individual w/Inelg. Spouse		
3.	Full Name of Recipient:		
4.	SSN: 5. Phone #:()		
6.	Full Date of SSI Application:/ 7. DOB:		
8.	Month & Year of SSI Payment in Texas: (If this is a PE move, show month after month of move to Texas.)		
9.	Title II or Medicare Claim Number:		
10.	Name & Address (as shown on check legend) including Rep Payee:		
11. 14. 15.	Federal L/A: 12. Sex: 13. Current Month UM: \$ Current Month Wages: \$ Current Month NESE*: \$ [*Note: Current Month NESE = Total NESE for year + 12] Unpaid Medical Expenses 3 Months Prior to SSI Appl. (Y or N):		
16. 18.	Gross RSDI (Include in 14): \$ 17. Current SSI Check: \$ Effective Date of SSI Suspension: Current PSY:		
	Reason for Suspension:	DOD:	
	If Closed/Intervening Period of Eligibility, Give All Months of SSI Payments:		
	Change from Prior Manual Certification Sent on Item Changed: # Effective Date:		
	Change to:	*	
20	T cowtifu that the names and the	I certify that the person named above received SSI payments.	
20.	I certify that the person hamed abo	ve received SSI payments.	
	Social Security Administration	(Print CR Name)	
	(Address)	(Area Code & Telephone Number)	
	(City State Zip)		

TDHS MANUAL CERTIFICATION FOR MEDICAID ELIGIBILITY Exhibit 1